1600 INTRODUCTION

Nevada Medicaid's ICF/MR Program was established in 1971 to provide reimbursement for individuals residing in institutions for people with mental retardation or other related conditions. The Social Security Act specifies that these institutes must provide active treatment in addition to other Conditions of Participation. Many of the residents who are served by the program are also non-ambulatory, may have seizure disorders, behavioral problems, mental illness, can be visually or hearing impaired or have a combination of these conditions.

Nevada Medicaid has opted to provide services for people residing in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) as a benefit under the State Plan for Medical Assistance.

All Medicaid policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up, with the exception of the four areas where Medicaid and Nevada Check Up policies differ as documented in Chapter 3700.

1601 AUTHORITY

FEDERAL STATUTES, REGULATIONS, AND POLICIES GOVERNING THE ICF/MR PROGRAM.

The following are the relevant statutes, regulations, and State Operations Manuals (SOM) that govern the ICF/MR Program.

FEDERAL STATUTES governing intermediate care facilities for persons with mental retardation or a related condition (ICF/MR) – Social Security Act:

Section 1905(d) – Defines ICF/MR

Section 1905(a)(15) – Defines ICF/MR

Section 1902(a)(33) – Directs CMS to make independent and binding determinations

Section 1902(i)(1) – State plans for medical assistance and the ICF/MR program.

Section 1922 – Correction and Reduction Plans for ICF/MR

REGULATIONS governing the ICF/MR program – Title 42 of the Code of Federal Regulations (CFR)

42 CFR 435.1009 – Definitions relating to institutional status for the purpose of Federal Financial Participation (FFP)

42 CFR 440.150 – ICF/MR services

42 CFR 440.220 – Required services for the medically needy

42 CFR 442.118-119 – Denial of new admissions

42 CFR 483.400-480 – Conditions of Participation for ICF/MR

42 CFR 498.3-5 – Appeals procedures for determinations that affect participation in the Medicare program and for determinations that affect the participation of ICF/MR and certain NFs in the Medicaid program.

SURVEY procedures governing the ICF/MR program – State Operations Manual (SOM), Chapters 1, 2, 3, 9 – Exhibit 80 and Appendix J.

1602 DEFINITIONS

1602.1 ACTIVE TREATMENT

All services provided by the facility directly or under contract are part of the active treatment program, including the evaluations, Individual Program Plan, training and habilitation, behavior modification, recreation and social services, psychological and psychiatric services, nutrition services, medical services, dental services, preventive health services, nursing services, pharmacy services, physical and occupational therapy, speech therapy and audiology services, transportation, and vocational or pre-vocational services.

Active treatment includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services. Active treatment is directed toward acquiring the behaviors necessary for the recipient to function with as much self-determination and independence as possible and preventing or slowing the regression or loss of current optimal functional status.

A continuous Active Treatment Program consists of needed interventions and services in sufficient intensity and frequency to support the achievement of IPP objectives.

Active treatment does not include services to maintain generally independent recipients who are able to function with little supervision or without a continuous active treatment program.

1602.2 COMMON OWNERSHIP

Means an individual possesses ownership of or equity in a facility and in an entity serving that same facility.

1602.3 COMPREHENSIVE FUNCTIONAL ASSESSMENT

Comprehensive function assessments identify all of the recipients:

a. Specific developmental strengths, including individual preferences;
b. Specific functional and adaptive social skills the recipient needs to acquire;
c. Presenting disabilities and, when possible, their causes; and
d. Need for services without regard to their availability.

1602.4 COST

a. NECESSARY COST: A cost incurred to satisfy an operation need of the facility in relation to providing resident care.
b. PROPER COST: An actual recorded cost, clearly identified as to source, nature and purpose, and reasonable related to resident care in an ICF/MR.

c. REASONABLE COST: A reasonable cost is one that does not exceed that incurred by a prudent and cost-conscious facility operator.

1602.5 ESSENTIAL MEDICATIONS

Essential medications are those which are medically necessary to counteract severe pain and/or to sustain life, limb, or eyesight. Restorative, rehabilitative, preventive, and maintenance medications must have appropriate corresponding diagnoses in the resident's chart to be considered essential.

1602.6 FULL-TIME EQUIVALENTS

Full-time equivalents relates to a staff member who works not less than 35 hours worked in a five-day work week.

1602.7 INDIVIDUAL PROGRAM PLAN (IPP)

An individual program plan is developed for each recipient by an interdisciplinary team utilizing Person-Centered-Planning. The plan is based on accurate, comprehensive, functional assessments to identify the recipient's needs. It includes specific, measurable objectives to meet the recipient's needs and written programs to implement the objectives.

1602.8 INTERDISCIPLINARY TEAM (IDT)

The Interdisciplinary Team is comprised of professionals, and when appropriate paraprofessionals and non-professionals, who possess the knowledge, skill and expertise necessary to accurately identify the comprehensive array of the recipient's needs and design appropriate services and specialized programs responsive to these needs.

The interdisciplinary team, which evaluates the recipient and develops, reviews, and revises the plan of care, must include:

a. A physician;
b. A registered nurse;
c. At least one member of the IDT must be a Qualified Mental Retardation Professional (QMRP); and
d. Other professionals, as appropriate, to develop and review the plan. The other professions which may be represented on the IDT include:
    1. A physical or occupational therapist;
    2. A social worker;
    3. A recreation therapist;
    4. An educator or vocational counselor;
    5. A speech - language pathologist;
    6. A dietician;

7. A psychologist;
8. A psychiatrist;
9. A dentist;
10. A pharmacist; or
11. Direct care staff.

1602.9 INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF/MR)

An institution (or distinct part of an institution), which is primarily for the diagnosis, treatment, or rehabilitation for persons with mental retardation or a related treatment, or rehabilitation for persons with mental retardation or a related condition. In a protected residential setting, an ICF/MR facility provides ongoing evaluation, planning, 24-hour supervision, coordination, and integration for health and rehabilitative services to help individuals function at their home.

1602.10 INTERMEDIATE CARE SERVICES FOR THE MENTALLY RETARDED

Health and rehabilitative services provided to a mentally retarded person or person with a related condition. The services are certified as needed and provided in a licensed inpatient facility.

1602.11 MEDICAL CARE PLAN

This plan of treatment is developed in coordination with licensed nursing personnel by a licensed physician, if the physician determines that the recipient requires 24 hour licensed nursing care. Thus, recipients with chronic but stable health problems such as epilepsy do not require medical care plans. The medical care plan must be integrated with the Individual Program Plan.

1602.12 PATIENT LIABILITY

Patient liability is that portion of the recipient's income which must be paid to the facility toward the cost of care.

1602.13 PERSON WITH MENTAL RETARDATION OR A RELATED CONDITION

42 CFR, Section 483.102(b)(3) states an individual is considered mentally retarded if he or she has a level of retardation (mild, moderate, severe or profound). A person with mental retardation demonstrates significant subaverage general intellectual functioning resulting in, or associated with, concurrent limitations in two or more adaptive skills areas which are manifested during the developmental period prior to age 18 years.

As defined in 42 CFR, Section 435.1009, "persons with related conditions" means individuals who have a severe, chronic disability that meets all of the following conditions:
Attributable to:

a. Cerebral palsy or epilepsy; or Any other condition, other than mental illness, closely related to mental retardation, resulting in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requiring similar treatment and services.
b. Manifested before the person reaches age 22 years.
c. Likely to continue indefinitely.
d. Results in substantial functional limitations in three or more of the following areas of major life activity:
1) Self-care, 2) Understanding and use of language, 3) Learning, 4) Mobility, 5) Self-direction, or 6) Capacity for independent living.

1602.14 QUALIFIED MENTAL RETARDATION PROFESSIONAL (QMRP)

A qualified mental retardation professional is a person who has one or more years experience in working with persons with mental retardation and is from one of the following professions:

a. A psychologist with a master's degree from an accredited program. A psychologist who is hired or subcontracted with after July 1, 1986 must be certified by the Nevada State Board of Psychological Examiners.
b. A doctor of medicine or osteopathy licensed in Nevada.
c. A professional dietician who is eligible for registration by the American Dietetics Association.
d. A social worker licensed by the Nevada State Board of Examiners for Social Workers.
e. An occupational therapist who has a current registration issued by the American Occupational Therapy Association or another comparable body.
f. A physical therapist who has a current registration to practice physical therapy issued by the Nevada State Board of Physical Therapy Examiners.
g. A speech pathologist or audiologist who is licensed by the State of Nevada Board of Audiology and Speech Pathology and has a current certificate of clinical competence issued by the American Speech and Hearing Association or another comparable body.
h. A registered nurse licensed in Nevada.
i. A professional recreation specialist who has a Bachelor's degree in recreation or in a specialty area such as art, dance, music, or physical education.
j. A human services professional who has at least a Bachelor's degree in a human services field (including but not limited to: sociology, special education, rehabilitation counseling, and psychology).

1602.15 TRAINING AND HABILITATION SERVICES

Training and habilitation services are those services which are intended to aid the intellectual, sensorimotor, and emotional development of an individual.

These services include instruction in self-help skills, social skills, and independent living activities with the goal, when feasible, of enabling individuals to function in community living situations.

1603 POLICY

1603.1 Intermediate Care Facilities for the Mentally Retarded (ICF/MR) must be certified and comply with all Federal Conditions of Participation in eight areas, including management, client protections, facility staffing, active treatment services, client behavior and facility practices, health care services, physical environment and dietetic services.

In Nevada, the Bureau of Licensure and Certification of the Nevada State Health Division (BLC) licenses ICF/MR facilities, conducts surveys and recommends certification of the facilities as Medicaid providers.

1603.1A COVERAGE AND LIMITATIONS

1. ADMISSION AND CONTINUED STAY CRITERIA

a. The recipient must be diagnosed as mentally retarded or have a condition related to mental retardation. Some standardized scales which can be used to determine level of mental retardation include, but are not limited to, the Vineland Social Maturity Scale, the Adaptive Behavior Scale, and the Behavior Development Survey.

b. The recipient must have an Individual Program Plan (IPP).

c. A physician must certify the need for ICF/MR care prior to or on the day of admission (or if the applicant becomes eligible for Medicaid while in the ICF/MR, before the Nevada Medicaid Office authorizes payment).

d. The certification must refer to the need for the ICF/MR level of care, be signed and dated by the physician, and be incorporated into the resident's record as the first order in the physician's orders.

e. Recertification by a physician or a nurse practitioner of the continuing need for ICF/MR care is required within 365 days of the last certification.

In no instance is recertification acceptable after the expiration of the previous certification.

f. The physical exam must document the resident does not have any active communicable, contagious, or infectious disease. This does not include residents with AIDS or AIDS-related conditions. Such residents are considered disabled under Section 504 of the Rehabilitation Act of 1973, if the condition substantially limits a major life activity (e.g., self care, walking, seeing, hearing, speaking, breathing, learning, or working).

g. The IDT evaluation documents that the recipient needs more intensive treatment than can be provided in a day treatment program or a community residential program.

The IDT evaluation documents that the recipient needs and can probably benefit from the active treatment program. The program is directed toward the acquisition of behaviors necessary to maximize the recipient's possible independence and self determination or to prevent or decelerate regression or loss of the recipient's current level of functioning for a recipient for whom no further positive growth is demonstrable.

h. The IDT has developed an appropriate Individual Program Plan based on its evaluation and reevaluated the plan as required.

i. The recipient had Medicaid Eligibility for services.

j. Provided in Medicaid certified participating facilities.

1603.1B PROVIDER RESPONSIBILITY

1. MEDICAID ELIGIBILITY

The provider is responsible to verify a recipient's Medicaid eligibility. The Electronic Verification System (EVS) may be used.

Refer to Chapter 100 of the Medicaid Services Manual for detailed information on application and eligibility categories.

2. FACILITY CERTIFICATION

Certification of compliance with federal requirements for participation in the Medicaid program is required; contact Bureau of Licensure and Certification in the Nevada State Health Division for information and procedures.

The facility must also have a valid Provider Agreement with the Nevada Medicaid Office; the Agreement must be co-terminus with Medicaid's period of certification, including any automatic cancellation dates imposed by CMS. The maximum duration of a Provider Agreement is 12 months.

3. PRELIMINARY ASSESSMENT

The Interdisciplinary Team (IDT) as must complete a preliminary assessment of each recipient prior to admission to the facility.

The preliminary assessment must include background information and currently valid assessments of functional, developmental, behavioral, social, health, and nutritional status to determine if the facility can provide for the recipient's needs, if the recipient is likely to benefit from placement in the facility, and what services are needed to meet those needs.

4. PSYCHOLOGICAL EVALUATION

There must be a psychological evaluation documenting the need for care which must be completed within three months before admission and prior to authorization of payment.

In an urgent or emergency initial ICF/MR placement, a psychologist may review the most recent psychological evaluation and document with a progress note or addendum to the psychological evaluation that the recipient is eligible and needs ICF/MR placement. The note or addendum must confirm the recipient's specific level of retardation or identify the condition related to mental retardation and be signed and dated within 90 days prior to admission or on the admission date. This progress note or addendum must be attached to the most recent psychological evaluation.

For readmission and discharge to another ICF/MR, a new psychological evaluation is not required unless the IDT determines the existing evaluation is no longer accurate.

5. PHYSICIAN'S CERTIFICATION AND MEDICAL PLAN OF CARE

The physician must complete a medical plan of care if the resident requires 24-hour licensed nursing care. It must include:

a. Diagnoses, symptoms, complaints, and complications indicating the need for admission;

b. Any orders for:

1. medications;

2. treatments;

3. restorative and rehabilitative services;

4. activities;

5. therapies;

6. diet;

7. medical equipment utilized to help treat medical conditions, such as helmets or orthopedic splints; and

8. special procedures designed to meet the objectives of the plan of care.

6. THIRTY–DAY EVALUATION RECORD REQUIREMENTS

Within 30 days of admission, the following assessments and evaluation which were completed (as appropriate to the recipient's needs) must be entered in the resident's record.

a. A physical examination and history which was completed within five days prior to or 30 days after admission. The examination and history may be conducted by an advanced practitioner of nursing or physician's assistant, if within their scope of practice, or a physician. The examination must include screening for vision and hearing.

b. A complete dental examination which is completed within twelve months prior to or one month after admission.

c. Evaluation of nutritional status which includes the determination of diet adequacy, total food intake, potential need for additives or supplements, and the skills associated with eating or feeding, food services practices, monitoring, and supervision of the resident's own nutritional status.

d. Routine laboratory examinations as determined necessary by a physician.

e. Speech and language screening.

f. Social assessment which includes, but is not limited to, family history, social relationships and interactions with peers, friends and relatives, and social development.

g. Active Treatment Schedule.

h. A nursing assessment which includes medication and immunization history, developmental history, and current health care needs.

i. Assessment of sensorimotor development which includes the development of perceptual skills which are involved in observing the environment and making sense of it; the development of those behaviors which primarily involve muscular, neuromuscular, or physical skills and varying degrees of physical dexterity; the identifying the extent to which corrective, orthotic, prosthetic, or support devices would impact on functional status.

j. Assessment of affective development which includes the development of behaviors which relate to the recipient's interests, attitudes, values, and emotional expressions.

k. Assessment of cognitive development which refers to the development of those processes by which information received by the senses is stored, recovered, and used

including the development of the processes and abilities involved in memory and reasoning.

l. Assessment of adaptive behaviors and independent living skills which includes the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected of their age and cultural group and skills such as meal preparation, laundry, bed making, budgeting.

m. Assessment of vocational or prevocational development, as applicable, which includes work interests, work skills, work attitudes, work related behaviors and present and future employment options.

All of the assessments must describe what recipients can and cannot do in terms of skills needed within the context of their daily lives.

In addition, the assessments must:

a. Identify the recipient's present problems and disabilities and where possible, their causes;

b. Identify the recipient's specific developmental strengths;

c. Identify the recipient's specific developmental and behavioral management skills;

d. Identify the recipient's need for services without regard to the actual availability of services needed.

7. INDIVIDUAL PROGRAM PLAN (IPP)

a. Within 30 days of admission, the IDT develops an Individual Program Plan for each resident based on the interdisciplinary professional comprehensive evaluations.

b. The purpose of the IPP is to help the individual function at the greatest physical, intellectual, social, or vocational level the recipient has presently or can potentially achieve.

c. The interdisciplinary team must prepare an IPP which includes opportunities for individual choice and self management and identifies the discrete measurable criteria-based objective the recipient is to achieve, and the specific individualized program of specialized and generic strategies, supports and techniques to be employed. The IPP must be directed toward the acquisition of the behaviors necessary for the recipient to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.

8. IMPLEMENTATION OF CONTINIOUS ACTIVE TREATMENT

a. The ICF/MR facility must provide active treatment. Once the IDT has developed the recipient's IPP, the recipient must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the plan.

b. The individual's time in the home or living unit must maximize toward further development and refinement (including self-initiation) of appropriate skills.

c. For the active treatment process to be effective, the overall pattern of interaction between staff and a recipient must be related to the comprehensive functional assessment and the IPP.

d. Except for those facets of the individual program plan which must be implemented by licensed personnel, each recipient's program plan must be implemented by all staff who work with the recipient, including professional, para-professional, and other staff, including direct care staff.

e. The facility must ensure that during staff time spent with each recipient, the staff members are able to provide needed interventions or reinforce acquired skills in accordance with the program plan. The activities of the ICF/MR must be coordinated with other habilitation and training activities in which the recipient may participate outside of the ICF/MR and vice versa, i.e. school or Community Training Center (CTC).

9. ACTIVE TREATMENT SCHEDULE

Within 30 days of admission to the facility, staff must develop an active treatment schedule which outlines the current active treatment program and is readily available for review by relevant staff. The schedule should direct the intensity of the daily work of the staff and the recipient in implementing the individual program plan. To the extent possible, the schedule should allow for flexible participation of the recipient in a broad range of options, rather than on a fixed regimen.

The facility must develop an active treatment schedule for each recipient which:

1. Does not allow for periods of unscheduled activity of longer than three continuous hours;

2. Allows free time for individual or group activities using appropriate materials;

3. Includes planned outdoor period year-round;

4. Reflects some of the specific programs for the individual rather than a facility or unit-wide generic calendar.

10. QMRP REVIEWS

a. REVIEWS

A facility must have one or more QMRP's review the Individual Program Plan and assure it is revised as necessary. The frequency of the QMRP reviews are determined by the facility. The duties of the QMRP are:

1. Monitoring the delivery of each IPP;

2. Integrating and coordinating the various aspects of the active treatment program;

3. Reviewing each recipient's program plan and insuring it is revised as necessary, including but not limited to, situations in which the recipient:

   a. Has successfully completed an objective or objectives identified in the IPP;

   b. Is regressing or losing skills already gained;

   c. Is failing to progress toward identified objectives after reasonable efforts have been made; or

   d. Is being considered for new training.

4. Obtaining input and review by other IDT member when the revisions result in significant differences from the team's original intent;

5. Documents information relevant to the individual program plan, assuring it is recorded as changes occur.

11. ANNUAL IDT REVIEW

Within one year of the resident's admission date and at least once every 365 days thereafter, the IDT must re–evaluate each recipient and revise the Individual Program Plan. Revisions must be developed and implemented and recommendations acted upon within thirty days of the IDT meeting, unless other time frames are justified.

a. The annual review must include:

1. The advisability of continued ICF/MR placement versus an alternative placement;

2. When the recipient is an adult, the need for guardianship and how the recipient can exercise his/her civil and legal rights;

3. The continuing appropriateness of the Individual Program Plan objectives;

4. The continuing appropriateness of services provided to reach the plan's objectives;

5. The progress (or lack there of) toward the plan's objectives;

6. Modification of the activities, objectives and/or training programs of the individual program plan as are necessary; and

7. A comprehensive functional reassessment to be based upon:

   a. Physical examination including a vision and hearing screening, which may be completed by a physician or an advanced nurse practitioner;

   b. Dental examination;

   c. Social reassessment;

   d. Physician's recertification of need for ICF/MR;

   e. Nursing reassessment;

   f. Routine screening laboratory tests as determined necessary by the physician;

   g. Nutritional reassessment;

   h. The IDT must determine whether other assessments are still accurate. Accurate assessments have:

   i. Current, relevant and valid data;

   j. Skills, abilities and training needs identified which correspond to the resident's actual status; and

   k. The cultural background and experiences of the resident reflected in the choice, administration and interpretation of the assessments.

   Assessments which are no longer accurate must be revised. The case record must document that the IDT has reviewed the assessments and determined which need updating.

   Assessments which must be reviewed by the IDT and revised as recommended by the IDT are:

   a. Sensorimotor, affective and cognitive development;

b. Adaptive behaviors and independent living skills; and

c. Vocational and prevocational development as applicable.

12. OCCUPANCY REPORTS

To assist in appropriate use of available beds, the facility must complete the Monthly Facility Occupancy Report indicating the actual census as of the first day of each month. This report is due by the fifth day of the following month. The occupancy report may be submitted electronically by using the DHCFP website at http://www.dhcfp.state.nv.us.

13. INCIDENT REPORTS

Incidents involving any potential harm to a resident in or around the facility must be:

a. Recorded on an adequate form;

b. Reported to the resident's physician or his alternate immediately if there is serious harm;

c. Reported to the family member, authorized representative or legal guardian; and

d. Evaluated by a nurse.

Incident documentation may be maintained apart from the resident's chart but, upon request, must be made available to authorized representatives of the Division of Health Care Financing and Policy (DHCFP) and/or Nevada State Health Division.
A facility must report to the Nevada Medicaid Office by telephone, within 48 hours, any incident in or about the facility which results in the death of or serious injury to any Medicaid resident by other than natural causes.

1603.1C RECIPIENT RESPONSIBILITY

1. Recipients and/or their authorized representative are responsible to apply for and to maintain Nevada Medicaid eligibility by cooperating with the Welfare Division in providing information necessary to determine eligibility.
2. Application for services is made directly through the service provider in conjunction with the Health Division's Mental Health and Developmental Services.

3. The recipient and the recipient's family/guardian should participate in developing the Individual Program Plan (IPP) unless the QMRP documents that such participation is inappropriate or unobtainable. If the recipient is a legally competent adult, he/she may request that his/her family not be involved in the planning process.

4. The recipient is responsible to participate in the active treatment program as described in the IPP.

1603.1D AUTHORIZATION PROCESS

1. GENERAL REQUIREMENTS

a. Prior authorization by the Nevada Medicaid Office is required for payment for care in an ICF/MR.

b. Authorization will be given only after a determination by the Nevada Medicaid Office that ICF/MR admission criteria have been met.

c. Authorization cannot be given for a resident whose eligibility status is pending. However, if eligibility is established retroactively, Medicaid may authorize retroactive payment to the facility for necessary services at the ICF/MR level of care which have been certified by a physician.

2. ICF/MR TRACKING FORM

The facility must submit an ICF/MR Tracking Form to Nevada Medicaid within 72 hours of an admission, readmission, and Medicaid eligibility determination. This form must be faxed to the Nevada Medicaid Office. At a future date, procedures will be developed for the electronic submission of this information to the state.

3. PRE-PAYMENT REVIEW

Pre-Payment Review packets must be submitted to the Nevada Medicaid Office (NMO) within 45 days of admission, readmission, annual review or newly Medicaid eligible (first time billing).

The below required attachments are referred to as a Pre-Payment Review packet. The pre-payment review packet serves as documentation to assess the appropriateness of placement. Once the Pre-Payment Review packet has been approved the facility will be notified by receiving a Billing Authorization letter. An ICF/MR will not be able to bill for services until they have received the Billing Authorization letter.

a. Required Attachments for Pre-Payment Review Packets
   1. Copy of the original ICF/MR Tracking Form;

   2. History & Physical Examination (most recent);

   3. Acute Discharge Summary (if there was a hospital stay which lasted longer than 48 hours);

   4. The most recent psychological test results documenting the recipient's level of retardation or existence of a "related condition";

5. Minutes of the most recent IDT meeting (Initial, Readmission, or Annual) that includes a dated sign-in sheet, a Nursing Assessment, Nutritional Assessment, Social Services Assessment and documentation of a dental exam within the past year.

6. The current Individual Program Plan (IPP) developed by the Interdisciplinary Team (IDT), and Active Treatment Schedule.

7. Physicians admission orders/certification for ICF/MR level of care.

b. Complete Pre-Payment Review Packet

If the packet has information which is incomplete or inaccurate, the packet will be returned to the facility, with the Additional Information form identifying the problem. The facility must review this request, make necessary corrections or provide additional information to assure all areas are addressed prior to resubmitting the packet. A facility staff member(s) must initial any alterations.

1603.2 READMISSION PROCEDURES

1603.2A COVERAGE AND LIMITATIONS

Refer to Section 1603.1A of this Chapter.

1603.2B PROVIDER RESPONSIBILITIES

1. Hospital or Nursing Facility Discharge/Readmission

If a recipient is discharged to a hospital or nursing facility from the ICF/MR and returns to the same ICF/MR, the following procedures are required:

a. Within 72 hours of the recipient's discharge, the facility must complete and submit to the Nevada Medicaid Office (NMO) an ICF/MR Tracking Form.

b. Within 72 hours of the recipient's return to the ICF/MR, the facility must complete and submit the ICF/MR Tracking form.

c. Prior to or on the date of return to the ICF/MR, a physician must complete the physician's certification and update the physician's orders.

d. The IDT determines whether assessments are still accurate. Assessments which are not accurate must be revised. The case record must show that the IDT has reviewed

all assessments and determined which need updating. This could be noted on each assessment which does not need revising or in the minutes of the IDT meeting.

On or prior to the date of admission, the IDT must review and revise the Individual Program Plan (IPP). If the IDT finds the objectives are appropriate and do not need revising, they must so note in the case records. This notation may be in the IDT minutes or on the plan objectives which are not being revised.

e. The facility must obtain the hospital's discharge summary if the hospital stay was for longer than 48 hours and file it in the recipient's record.

f. Within 45 days submit the authorization packet to the Nevada Medicaid Office.

g. If the recipient has been out of the ICF/MR for more than 30 days, all the requirements for a new admission must be met.

h. Admission to an ICF/MR from another ICF/MR is a new admission to the accepting facility. Each ICF/MR has a separate Medicaid provider number and each is considered a separate facility even if multiple facilities share a governing body.

2. DISCHARGE/READMISSION TO/FROM HOME OR COMMUNITY BASED PLACEMENT

If a recipient is transferred from an ICF/MR into a residential community based or home placement, the following procedures apply:

a. The facility must submit the ICF/MR Tracking form to the NMO within 72 hours of when the recipient is transferred.

b. If the recipient returns to the ICF/MR within the trial placement period (within 30 days of leaving the ICF/MR) the facility must:

1. Complete the form within 72 hours of the recipient's return and submit it to NMO.

2. On or prior to the date of readmission, the IDT determines whether assessments are still accurate. Assessments which no longer are accurate must be revised. The case record must show that the IDT has reviewed all assessments and determined which need updating.

c. If a recipient is transferred from one ICF/MR to another ICF/MR, the following procedures must be followed:

1. The discharging facility must complete a ICF/MR tracking form within 72 hours of discharge and submit copies to the Nevada Medicaid Office.

2. The discharging facility must develop a final summary of the recipient's developmental, behavioral, social, health and nutritional status and plan to help the recipient adjust to the new placement. With the consent of the recipient/parents (if a minor child)/legal guardian, the summary must be provided to authorized persons and agencies.

3. Within thirty days after admission, the admitting ICF/MR Interdisciplinary Team (IDT) must perform accurate assessments or reassessments as needed (defined in Section 1603.2B1.d1).

   On or prior to the date of readmission, the IDT must review and revise the Individual Program Plan. If the IDT finds that the objectives are appropriate and do not need revising, it must be noted in the case record. This notation may be in the IDT minutes or on the plan objectives which are not being revised.

   a. Prior to or on the date of return to the ICF/MR, a physician must complete the physician's certification (See Manual Section 1603.1A2) and update the physician's orders.

   b. Within 45 days of the readmission, the facility must submit the 3049 authorization packet, defined in Manual Section 1603.1D, to the Nevada Medicaid Office.

   c. If the recipient returns to the ICF/MR after the trial placement period has ended, all the requirements for a new admission must be met with one exception.

      The IDT determines whether assessments are still accurate. Assessments which are not accurate must be revised. The case record must show that the IDT has reviewed all assessments and determined which need updating. This could be noted on each assessment which does not need revising or in the minutes of the IDT meeting.

1603.3 OUT-OF-STATE ICF/MR PLACEMENT

Nevada Medicaid must prior authorize all out-of-state ICF/MR placements for all Medicaid recipients arranged by any agency, individual, or district office. The Nevada Medicaid Office will issue a Prior Authorization Request (PAR) to the out-of-state facility and the Welfare District Office will arrange transportation. Residents placed in out-of-state facilities without Medicaid authorization will be considered residents of the state of location.

1603.3A COVERAGE AND LIMITATIIONS

PRE-PLACEMENT PROCEDURES

The following pre-placement procedures must be followed before Nevada Medicaid will authorize an out-of-state ICF/MR placement:

1. All appropriate facilities within Nevada must first be contacted for a possible placement. The facilities contacted and reasons for not accepting the recipient must be documented.

2. Documentation, if applicable, is required from a state or county agency verifying responsibility for payment of educational expenses, since this is not a Medicaid benefit. This is for recipients under age 22 and who have not completed state schooling requirements.

3. If there is no burial coverage and family is not willing/able to purchase it, a burial guarantee must be obtained from the Division of Child and Family Services, the Department of Education or a county.
4. If the individual is incompetent or suffers from diminished capacity and there is no family, legal guardian or significant other involvement, efforts must be made to have the Public Administrator or a guardian appointed to handle possible legal, health or financial matters prior to out-of-state placement.

5. The individual (and family or custodial agency if applicable) must agree in writing to out-of-state placement.

6. The out-of-state ICF/MR must be a Nevada Medicaid provider.

1603.3B PROVIDER RESPONSIBILITY

All of the following are required for authorization for an out–of–state placement:

1. Completed Out–of–State Intake Questionnaire.

2. Current History and Physical exam and list of current medications.

3. Proof of burial coverage or guarantee (if available).
4. Statement from the recipient, if a minor from his/her parent, or from a legal guardian agreeing to an out–of–state placement.

5. A list of all Nevada ICF/MR facilities contacted including date contacted, the name of the person at the ICF/MR who denied placement and the reason for denial.

6. A letter verifying coverage of educational costs for a recipient who is under age 22 and has not completed high school.

7. Social history and assessment.

8. Psychological evaluation verifying ICF/MR eligibility as a person with mental retardation or with a condition related to mental retardation.

All of these are sent to the Nevada Medicaid Office, Attention: Out–of–state Placement Coordinator.

1603.4 TRANSPORTATION

Transportation for services the facility is required to provide on-site is not reimbursable.

Medicaid will reimburse for transportation in a medical emergency situation and to Medicaid covered services which are not available at the facility.

Refer to Chapter 1900 for details on transportation.

1603.5 ABSENCES

1603.5A COVERAGE AND LIMITATIONS

1. Payment for therapeutic leave of absence, or reserved beds, may be made in an (ICF/MR), subject to the following conditions:

   a. The purpose of the therapeutic leave of absence is for rehabilitative home and community visits including preparation for discharge to community living;

   b. The patient's attending physician authorizes the therapeutic leave of absence and the plan of care provides for such absences;

   c. An ICF/MR will be reimbursed their per diem rate for reserving beds for Medicaid recipients who are absent from the facility on therapeutic leave up to a maximum of twenty-four (24) days annually. For this purpose, annually is defined as a calendar year beginning on January 1 and ending on December 31 of the same year.

2. An absence for hospitalization or placement in a facility nursing which exceeds the Medicaid authorized maximum is not reimbursable.
3. If a recipient does not return from a home visit or family emergency and if the absence has been appropriately documented by the recipient's physician and the facility, the facility will not be penalized for the recipient's failure to return. This absence will be treated as a discharge effective the day the recipient was expected to return from leave.

1603.6 PROFESSIONAL SERVICES

In order to qualify for Medicaid reimbursement and provide services necessary to assure a comprehensive Active Treatment Program, ICF/MR facilities employ or contract with individuals who can assess recipient needs, participate in the IPP, and provide appropriate training and habilitation services. These support staff assist in providing those physical and social modifications

or interventions allowing the recipient to function and adapt to his/her physical and social environment.

1603.6A COVERAGE AND LIMITATIONS

1. RECREATION

a. Services for Recipients With Handicapping Conditions

Multiple handicapped or non-ambulatory recipients must:

1. Spend a major portion of the waking day out of bed;
2. Spend a portion of the waking day out of the bedroom area;
3. Have planned daily activity and exercise periods;
4. Move around with various methods and devices whenever possible; and
5. Have recreation areas and facilities designed and constructed or modified so that they, regardless of their disabilities, have access to them.

b. Coordination With IPP

Recreation services should be a coordinated part of the recipient's Individual Program Plan.

A recreation assessment must be completed or updated within 30 days of admission into an ICF/MR. If recreation therapy is provided, an annual re-evaluation by the recreational therapist is required. If the IDT recommends during an IDT meeting that a re-assessment be completed by the recreational therapist, one must be completed within 30 days of the recommendation.

c. Recreation Services Objectives

Recreation services should:

1. Provide activities designed to meet individual, personal, and therapeutic needs in self-expression, social interaction, and entertainment;
2. Develop skills, including physical and motor skills, and interests leading to enjoyable and satisfying use of leisure time; and
3. Improve socialization and increase interaction with others.

d. Recreational Staff Qualifications

1. To be designated as a professional recreation therapist the staff member must have a Bachelor's Degree in recreation, or a related specialty area, such as art, dance, music, or physical education.

2. Sufficient qualified staff and support staff should be available to carry out recreational services in accordance with stated objective in the IPP.

2. SOCIAL SERVICES

a. PURPOSE OF SOCIAL SERVICES

Social Services must be directed toward:

1. Maximizing the social functioning of each recipient;

2. Enhancing the coping capacity of each recipient's family;

3. Asserting and safeguarding the human and civil rights of the recipient and his/her family; and

4. Fostering the human dignity and personal worth of each recipient.

b. PRE-ADMISSION SERVICES

During the evaluation process to determine whether or not admission to the ICF/MR is necessary, social workers must help the recipient and his/her family:

1. Consider alternative services, based on the individual's status and relevant family and community factors; and

2. Make a responsible choice as to whether and when residential placement is indicated.

c. ONGOING EVALUATION AND MONITORING OF RESIDENTS

Social workers must participate in the interdisciplinary team meetings for each recipient for the purposes of monitoring and following up on program plans.

d. LIAISON WITH RECIPIENT'S FAMILY AND THE COMMUNITY

The social worker must, as appropriate, provide liaison between the recipient, the ICF/MR, the family, and the community.

e. DISCHARGE PLANNING

1. In addition to participation in the development of the discharge plan, social workers must:

a. Help the family participate in planning for the recipient's return to home or other community placement; and

b. Provide systematic follow-up to assure referral to appropriate community agencies after the recipient leaves the facility.

2. If a recipient is to be either transferred or discharged, the facility must:

a. Have documentation in the resident's record that the resident was transferred or discharged for good cause.

Transfer means the temporary movement of an individual between facilities or the permanent movement of an individual between living units of the same facility. Discharge means the permanent movement of an individual to another residence that is not under the jurisdiction of the facility's governing body. Moving an individual for good cause means for any reason that is in the best interest of the individual.

The recipient, his/her family, advocate and/or guardian should be involved in any decision to move him/her.

b. Provide a reasonable time to prepare the recipient and his or her parents or guardian for the transfer or discharge (except in emergencies).

f. SOCIAL WORK STAFF QUALIFICATIONS

A social worker must be licensed as an Associate in Social Work or a Social Worker by the Nevada State Board of Examiners for Social Work.

3. PSYCHOLOGICAL AND PSYCHIATRIC SERVICES

a. PURPOSE OF PSYCHOLOGICAL SERVICES

Psychological services must be provided to:

1. Maximize each recipient's development; and

2. Help recipient's acquire:

a. Perceptual skills;

b. Sensorimotor skills;

c. Self-help skills;

d. Communication skills;

e. Social skills;

f. Self-direction;

g. Emotional stability; and

h. Effective use of time, including leisure time.

b. PSYCHOLOGICAL SERVICES

The facility must provide a psychological service program for recipients which includes:

1. Evaluations which must be done at least every three (3) years for recipients under age 18 and every five (5) years for recipients aged 18 or older. The evaluations must document that the resident has mental retardation. The level of retardation may be two levels if the recipient's functioning is in between them, e.g., moderate-severe.

2. Consultation;

3. Therapy;

4. Program development;

5. Administration and supervision of psychological services;
6. Staff training;

7. Continuing inter-disciplinary evaluation of each recipient and development of plans for habilitation services; and

8. When appropriate, periodic review and revision of program plans.

c. PSYCHOLOGICAL STAFF QUALIFICATIONS

1. A psychologist must have at least a Master's degree from an accredited program and experience or training in the field of mental retardation. If hired or subcontracted with after July 1, 1986, the psychologist must be certified by the Nevada State Board of Psychological Examiners.

2. A psychologist who is the facility's QMRP must meet the qualifications in Manual Section 1603.1B.10.

d. PSYCHIATRIC SERVICES

1. Psychiatric services should be provided when indicated by the Interdisciplinary Team for psychotherapy, medication management and/or consultation.

2. To provide services in a ICF/MR a psychiatrist must be a medical doctor licensed to practice psychiatry in the State of Nevada.

4. DENTAL SERVICES

Through a formal arrangement with a dentist licensed to practice dentistry or dental surgery as defined in Nevada Revised Statutes NRS 631.215, the ICF/MR facility must provide:

a. A comprehensive diagnostic dental examination within one month of admission to the facility unless the recipient has had a dental examination within the 12 months prior to admission.

b. Periodic examination and diagnosis done at least annually for each recipient.

c. Necessary access to the services specified under MSM Chapter 1000, excluding sealants, orthodontia, pharmacy services, fluoride treatments, and fluoride treatments with prophylaxis.

d. For children under 21 years of age residing in an ICF/MR referred for dental care through the Healthy Kids Program (also know as Early and Periodic Screening Diagnosis and Treatment-EPSDT), a Medicaid dental provider may bill directly to Medicaid.

e. For adults 21 years and older residing in an ICF/MR, dental treatment for emergency extractions, palliative care, and dentures can be billed to Medicaid by a Medicaid dental provider in accordance with MSM Chapter 1000 guidelines and limitations.

f. If appropriate, the dentist or dental hygienist may participate in the development, review, and updating of the Individual Program Plan (IPP) as part of the Interdisciplinary Team (IDT) process, either in person or by written report.

5. PHARMACEUTICAL SERVICES

a. PHARMACIST DUTIES

1. Upon admission, the pharmacist or registered nurse must obtain a history of prescription and non-prescription drugs used and enter this in the resident's record. This must be updated yearly.

2. The pharmacist must receive a copy for each resident of the physician's drug treatment order.

3. The pharmacist must maintain for each resident a record of all prescription and non-prescription medications dispensed including quantities and frequency of refills.

4. As appropriate the pharmacist should participate in the ongoing IDT evaluations and development of the individual program plan.

5. The pharmacist must establish quantity specifications for drug purchases and insure that they are met.

6. The pharmacist must review each resident's drug regimen at least quarterly.

7. On a monthly basis the pharmacist must complete the Checklist for Pharmacist Consultant (3232).

b. STAFF OR CONSULTANT

1. If a facility does not employ a licensed pharmacist, it must have an agreement, with a licensed pharmacist to provide consultation on methods and procedures for ordering, storage, administration, disposal, and recording of drugs and biologicals.

2. Payment for consultant pharmacist services are separate from payment for filling of prescriptions. With the consultant pharmacist, payment is made by the facility for a service to the facility. In the case of prescribed drugs, a provider payment is made by Medicaid to a pharmacy on behalf of the recipient. The individual furnishing consultant pharmacist services to a facility may or may not also be providing prescribed drugs to residents in that facility. However, when it is feasible, separation of consultant services and prescription services is encouraged.

c. LIMITATIONS

Nevada Medicaid reimburses the pharmaceutical provider directly for prescriptions which meet the definition of essential in Manual Section 1602.5.

The consultant pharmacist must review every drug ordered for compliance with this definition.

If drug therapy is observed which does not meet the definition of essential as stated in Manual Section 1602.10, future charges for the medication will be denied. Before this sanction is imposed, the facility and the pharmacy will receive advance notice.

If Nevada Medicaid does not receive appropriate justification within ten (10) days from the date of notification, all future charges for the medication will be denied.

6. PHYSICAL AND OCCUPATIONAL THERAPY

a. SERVICES

1. Physical and occupational therapy staff must provide treatment training programs which are designed to:

a. Preserve and improve abilities for independent function such as range of motion, strength, tolerance, coordination, and activities of daily living; and

b. Prevent, insofar as possible, irreducible or progressive disabilities through means such as the use of orthotic and prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations, and sensory stimulation.

2. Services must be coordinated with the recipient's physician and other medical specialists.

3. Services must include:

a. Evaluation;

b. Participation in developing treatment objectives as part of the IPP;
c. Procedures to reach objectives; and

d. Revision of objectives and procedures based on progress (or lack of).

b. STAFF AND QUALIFICATIONS

1. The ICF/MR must have available enough qualified staff and support personnel available either on staff or under contract to carry out the various physical and occupational therapy services in accordance with stated objectives in recipients' individual treatment plans.

2. Therapy assistants must work under the supervision of a qualified therapist.

3. To be designated as an occupational therapist, an individual must have a current registration issued by the American Occupational Therapy Association or another comparable body.

4. To be designated as a physical therapist an individual must have a current registration to practice physical therapy issued by the Nevada State Board of Physical Therapy Examiners.

7. SPEECH PATHOLOGY AND AUDIOLOGY SERVICES

a. SERVICES

Speech pathology and audiology services available to the ICF/MR must include:

1. Screening of recipients with respect to hearing functions which is completed by the physician or advanced nurse practitioner as part of the annual physical examination, and screening of recipients regarding speech functions;

2. Comprehensive audiological assessments of recipients as indicated by screening results, which were part of the recipient's physical examination, that include tests of puretone air and bone conduction, speech audiometry, and other procedures, as necessary, and the assessment of the use of visual cues;

3. Assessment of the use of amplification;

4. Provision for procurement, maintenance, and replacement of hearing aids, as specified by a qualified audiologist;

5. Comprehensive speech and language evaluations of recipients as indicated by screening results, including appraisal of articulation, voice, rhythm, and language;

6. Participation in the IDT Process and individual program plan development for individual recipients;

7. Treatment services as an extension of the evaluation process, which include:

a. Direct counseling with recipients;

b. Consultation with appropriate staff for speech improvement and speech education activities; and

c. Work with appropriate staff to develop specialized programs for developing each recipient's communication skills in comprehension, including speech, reading, auditory training, hearing aid utilization, and skills in expression, including improvement in articulation, voice, rhythm, and language;

8. Participation in in-service training programs for direct-care and other staff.

b. STAFF AND QUALIFICATIONS

A speech pathologist or audiologist must be licensed by the State of Nevada Board of Audiology and Speech Pathology and have a current certificate of clinical competence issued by the American Speech and Hearing Association or a comparable body.

8. LABORATORY SERVICES (Provided by the ICF/MR)

a. MANAGEMENT REQUIREMENTS

If a facility chooses to provide laboratory services, the laboratory must:

1. Meet the management requirements specified in 42 CFR 405.1316; and

2. Provide personnel to direct and conduct the laboratory services.

b. QUALIFICATIONS OF LABORATORY DIRECTOR

The laboratory director must be technically qualified to supervise the laboratory personnel and test performance and must meet licensing or other qualification standards established by the State with respect to directors of clinical laboratories. For those States that do not have licensure or qualification requirements pertaining to directors of clinical laboratories the director must be either:

1. A pathologist or other doctor of medicine or osteopathy with training and experience in clinical laboratory services; or
2. A laboratory specialist with a doctoral degree in physical, chemical, or biological sciences, and training and experience in clinical laboratory services.

c. DUTIES OF LABORATORY DIRECTOR

The laboratory director must provide adequate technical supervision of the laboratory services and assure that tests, examinations and procedures are properly performed, recorded, and reported.
The laboratory director must ensure that the staff:

1. Has appropriate education, experience, and training to perform and report laboratory tests promptly and proficiently;

2. Is sufficient in number for the scope and complexity of the services provided; and

3. Receives in-service training appropriate to the type and complexity of the laboratory services offered.

d. OTHER LABORATORY REQUIREMENTS

1. The laboratory must meet the proficiency testing requirements specified in 42 CFR 405.1314(a).

2. The laboratory must meet the quality control requirements specified in 42 CFR 405.1317.

3. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be approved by the Medicare program either as a hospital or an independent laboratory.

1603.7 REIMBURSEMENT RATE AND ALLOWABLE COSTS

1603.7A COVERAGE AND LIMITATIONS

1. PUBLIC ICF/MR FACILITIES – COST REIMBURSEMENT

A public ICF/MR is reimbursed under Medicare principles of retrospective reimbursement described in 42 CFR 405 and HCFA Publication 15.

Each facility is paid the lower of either billed charges or the agreed upon interim rate. In no case will payment exceed audited allowable costs.

2. PRIVATE ICF/MR – SMALL PROSPECTIVE RATE

a. Prospective Payment Rate

Private ICF/MR–Small facilities are paid a prospective payment rate for basic service costs, other than day training costs and property costs, on a per–patient–day basis. Day training costs and property costs, excluded from the basic prospective rate, are reimbursed under Medicare principles of retrospective cost reimbursement.

1. The initial basic prospective payment rate, per patient day, was the average of costs (excluding residential staff wages and benefits) of the four private ICFs/MR–Small, operating a full year, from 1993 audited cost reports. Costs were indexed to the common time period of December 31, 1993. Residential staff wages and benefits cost was calculated, and added to the average, at the rate of $11 per hour for 6.4 full–time equivalents. The initial rate period was one year from July 1, 1995 through June 30, 1996. Therefore, the rate was adjusted for inflation for the period June 30, 1993 – December 31, 1995 (the midpoint of the cost report period to the midpoint of the rate period), by the

percentage change in the Recipient Price Index – All Urban and Clerical Workers (CPI), for calendar year 1993 times 2.5.

2. The basic prospective payment rate is adjusted annually on July 1 of each year. The adjustment is accomplished by 1) the percentage increase in the CPI for the previous calendar year; or 2) re-basing the rate of all private facilities using audited cost reports completed at the close of the facility's fiscal year. The method of adjustment is at the discretion of the Medicaid Division. However re-basing will be performed at least once every three years. Upon re-basing, costs are indexed to a common point in time, arrayed from highest to lowest, and the cost of the 60th percentile facility is selected. The rate is further adjusted for inflation by the CPI.

3. In addition, the rate is adjusted for increased costs of services over basic inflation, which are determined to be necessary under new federal or state guidelines.

4. Day training costs must be approved by the Division of MH/MR. These approvals must be obtained annually for all residents and whenever there is an increase in the service rates.

5. Property costs consist of a property lease (or in the case of an owned facility, interest and depreciation) as well as depreciation of equipment, property insurance and property taxes. Equipment depreciation does not include automobiles.

Refer to the ICF/MR - Small Facility Cost Report Instructions for additional details.

b. Alternate Prospective Payment Rate

1. For state fiscal year 1996, a facility may receive an alternate prospective payment rate equal to its interim rate at June 30, 1995, or its actual audited costs, whichever is less, in lieu of the calculated rate under paragraph B.1.

2. For subsequent years, such facilities may receive the lesser of its alternate rate for the previous year adjusted by the percent increase in the CPI for the previous calendar year, or its actual costs, whichever is less, in lieu of the rate under paragraph B.1.

3. At such time as the total payments under section B.1. for any individual facility equals or exceeds the payments under this section, the provisions of paragraph B.1. are no longer applicable. For example, if a facility in its fiscal year 1996 would have received $500,000 in total payments under section B.1., and for the same period the facility received $500,000 or less under the alternate rate of section B.2., as determined subsequent to the facility's audit, the facility will come under the provisions of section B.2. in fiscal year 1997 and all future rate periods.

3. ALLOWABLE COSTS

In order to be considered allowable, any cost charged to this program must meet the definitions above of reasonable, necessary, and proper, and must be directly attributed to the correct account and cost center. Any question of an allowable cost that is not addressed within this chapter will be resolved by reference to HCFA Publication 15; if it is not addressed, it is the facility's responsibility to seek clarification from the Welfare Division's Deputy for Administrative Services, preferably before incurring the questionable expense. Payment by the ICF/MR for services not normally covered by Medicaid, if recommended by the IDT or required by HCFA or Nevada Medicaid, such as, assistive devices, are allowable costs.

Nevada Medicaid allows the costs for nutritional supplements (e.g., Ensure, Pediasure, etc.) when recommended in writing by a registered dietician and prescribed by a physician. The cost is included in the facility cost reports under Raw Food or Dietary.

4. COMMON OWNERSHIP

The facility must identify any organization related by common ownership or control from which services, facilities, and/or supplies are purchased; the cost of such purchases may not exceed the lower of actual cost to the related organization or the price of comparable items which could be purchased elsewhere.

5. UPPER LIMITS

In no case may Medicaid payment for an ICF/MR exceed the facility's customary charges to the general public.

In no case may Medicaid payment for an ICF/MR caring for more than 6 persons, exceed an upper limit determined by application of principles of reimbursement for provider costs under Title XVIII of the Social Security Act. All payment schedules under Medicaid are subject to the general payment limits imposed in 1861(v) and 1866 of the Act and implemented by regulations at 42 CFR 405.460 and 405.461.

6. ANCILLARIES

Medicaid may make direct payment for ancillary services provided to recipients when:

a. Such services are not directly provided by the facility as part of the rate; and

b. Required prior authorization has been obtained from the Nevada Medicaid Office.

1603.7B PROVIDER RESPONSIBILITY

COST REPORTING AND AUDIT

A complete set of financial statements together with all accounting records, ledgers, accounts, bills, contracts, and documents must be made available by the provider for inspection and examination by the Division of Health Care Financing and Policy and/or its agents upon request.

1. FILING COST REPORTS

a. At the close of its annual fiscal year, the facility must assign allowable costs to appropriate accounts in a uniform cost-reporting form prescribed by the Division of Health Care Financing and Policy. The accrual method of accounting and generally accepted accounting principles must be used.

Uniform cost reports and instructions for completion are available from the fiscal agent, First Health Services. Submission of alternate forms or any forms other than the most current does not constitute an acceptable filing.

b. Each facility must submit its annual report of allowable costs to First Health Services within three months of the close of its fiscal year.

1. A Facility may be granted a filing extension only upon demonstration of exceptional circumstances, and only after approval by the Medicaid Chief for Program Services.

2. In any case where a report is overdue, notice is given to the facility that payment will be suspended within 30 days after the due date. If the report is not received or an extension has not been requested and granted, all checks payable to the facility will be held.

c. When a provider experiences a change in ownership or terminates participation in the Medicaid program, the cost report is due no later than 45 days from the effective date of the change in ownership or termination from the program.

2. SUBSTANTIATING RECORDS

Each facility must maintain financial and statistical records sufficient to substantiate its reported costs for three calendar years after submission. These records must be available upon request to representatives of the Division of Health Care Financing and Policy, its subcontractor, and/or CMS.

a. At the time of audit, all records supporting claimed costs must be available at the facility. For any facility which maintains supporting documentation at some location other than the facility, adequate notice (usually 30 days) will be given prior

to the scheduled audit to allow the provider time to supply the original documentation at the facility.

b. During the course of the audit, any and all additional documentation, determined necessary by the Division of Health Care Financing and Policy and/or its designated representative to verify or substantiate reported costs and the facility's claim for reimbursement on the cost report, will be verbally requested from the facility. The requests for documentation will be followed up in writing and provided at the closing conference or by a certified. If the requested information is not received by the requestor within 30 days of the date the written request was received by the facility, reimbursement for the claimed cost will be considered undocumented and non-allowable on the cost report.

3. AUDIT

a. Within three months of receipt of the facility's cost report, a review (desk audit) will be completed by the Division of Health Care Financing and policy or its representative. On-site audits may be conducted to verify that:

1. Only allowable costs have been included;

2. Costs have been accurately determined and attributed by the facility; and

3. Reported costs are reasonable, necessary, and proper.

b. The proposed audit settlement is sent to the facility. If the facility disagrees over proposed findings, the facility should respond to the First Health Manager of Medicaid Audit. The First Health Manager will review all submissions and make whatever redeterminations are deemed necessary to close the audit. When agreement cannot be reached, see Manual 3100 for appeal procedures.

c. The final audit indicates the amount required for financial settlement. Arrangements for payment of a retroactive adjustment due to or from the facility are made on an individual basis by BC/BSN with the approval of the Chief for Medicaid Program Services.

d. Interest shall not be charged or payable by either party to the other with respect to any such adjustments required by the above audit.

4. RECORDS RETENTION

The facility and/or the Division of Health Care Finance and Policy must retain cost reports, audit reports, and all substantiating records for three years.

1603.8 PATIENT LIABILITY

DETERMINATION OF AMOUNT

Patient liability is determined by eligibility personnel in the local Welfare Division district office.

1603.8A COVERAGE AND LIMITATIONS

1. The following items are excluded when determining patient liability:

   a. $35 personal needs allowance;

   b. Maintenance allowance for spouse/dependent children. The Eligibility Certification Specialist determines if the recipient qualifies for the deduction based on Welfare Division financial criteria.

      The recipient and/or facility is responsible to insure the spouse/ dependents receive the maintenance allowance. Maintenance allowance deductions will be discontinued if information is received that the spouse/dependents are not receiving the maintenance allowance.

   c. Payments for health insurance premiums (except Medicare), deductibles, and coinsurance charges, which are not subject to payment by a third party. Residents must provide proof of payment.

   d. Payments for medical care made by the recipient recognized under state law, but not covered under the Medicaid program. (Residents must provide proof of payment.) Payments which circumvent Medicaid program limitations are not allowed. The other expense(s) must be approved by Nevada Medicaid.

2. Collection of Patient Liability

   When a case is approved or patient liability changes, the resident, facility, and First Health Services are notified of the amount and effective date. Collection of patient liability is the facility's responsibility. When collecting patient liability, the facility shall indicate amount and date received on the resident's Medical Certificate for that month.

   a. When a resident is discharged to an independent living arrangement, patient liability is prorated by dividing the total patient liability amount by the number of days in the month, to determine the daily rate, and multiplying the daily PL rate by the number of days the resident was in the facility. If patient liability is inadvertently collected before discharge, the remaining balance as determined by the Welfare Division shall be refunded to the resident.

   b. If a recipient is transferred mid-month from one facility to another, the discharging facility:

1. Collects the total patient liability;

2. Notes the name of the facility, dates of service, and amount of patient liability collected on the back of the Medical Certificate; and

3. Sees that the Certificate accompanies the recipient to the admitting facility.

c. If a recipient expires mid-month, the Welfare Division prorates patient liability as in A above, and notifies the facility of the amount.

3. Voluntary Payments

A Medicaid applicant/recipient may make voluntary payment to a medical facility from his/her own funds to reduce his/her resources below the Welfare Division's Medicaid eligibility resource limit. When a resident makes voluntary payment specifically to reduce resources, the Welfare Division district office should be notified immediately.

Recipients (or if minor children, parents) or legal guardians may authorize facilities to withdraw funds from their resident trust accounts using Authorization for Use of Patient Trust Funds (3402); or a recipient may withdraw funds from a private bank account and upon payment to the facility receive a receipt signed by the recipient and the facility. A copy of the Authorization (3402) must remain available in the resident's financial file for audit.

A new Authorization (3402) is required for <u>each</u> voluntary contribution, with the specific amount to be applied toward his/her care. The resident (or parent or guardian) must have a full understanding of what he/she is signing.

Voluntary payments may not be made for transportation to off–site providers.
Voluntary payments made by a Medicaid applicant or recipient to eliminate or prevent excess resources may not be refunded.

1603.8B PROVIDER RESPONSIBILITY

The facility may not charge recipients for items and services such as diapers, over the counter drugs (non-legend), combs, hairbrushes, toothbrushes, toothpaste, denture cream, shampoo, shaving cream, laxatives, shaves, shampooing, skin-care items, bedside tissues, disposable syringes, nail care, pads, catheters, laundry, durable or disposable medical equipment/supplies, stipends paid, based on recipient's needs, as part of the active treatment program, or any item covered by Medicaid in reimbursement to the facility or to other providers of care such as pharmacies, therapists, etc.

1603.8C RECIPIENT RESPONSIBILITY

1. PERSONAL NEEDS

If a recipient so requests, the facility may provide and charge the recipient for such items as cosmetics, after shave lotion and equipment, smoking supplies, stationery, postage, pens, pencils, newspapers, periodicals, alcoholic beverages, personal clothing, professional haircuts, long-distance telephone calls, dry cleaning of personal clothing, and services in excess of program limitations. If a recipient is charged for the above, accurate records must be kept including the recipient's authorization for payment.

1604 HEARINGS

Please reference Chapter 3100 for Medicaid Hearing process.

1605 REFERENCES AND CROSS REFERENCES

1605.1 MEDICAID SERVICES MANUAL (MSM)

Specific information about other Medicaid programs that may impact the provision of ICF/MR services may be found in the following chapters of the Medicaid Services Manual:

Chapter 100 Eligibility, Coverage and Limitations
Chapter 200 Hospital Services
Chapter 500 Nursing Facility Services
Chapter 600 Physician's Services
Chapter 700 Cost Containment and Rates
Chapter 800 Laboratory Services
Chapter 1000 Dental Care
Chapter 1100 Ocular Services
Chapter 1300 DME, Prosthesis and Disposable Supplies
Chapter 1900 Medical Transportation
Chapter 2100 Home and Community Based Services (HCBS) Waiver for Persons with Mental Retardation and Related Conditions
Chapter 3100 Medicaid Hearings
Chapter 3300 Surveillance and Utilization Review Section (SURS)
Chapter 3600 Managed Care Organization
Chapter 3700 Nevada Check Up

1605.2 CONTACTS

a. Nevada Division of Health Care Financing and Policy
1100 E. William Street Suite 102
Carson City, NV 89701
(775) 684-3600 Main Medicaid
1-800-992-0900 Toll Free
(775) 687-8724 (FAX)

b. First Health Services Corporation
Nevada Medicaid's Fiscal Agent and Quality Improvement Organization (QIO)
4300 Cox Road
Glen Allen, VA 23060
(804) 965-7400
www.fhsc.com

c. Bureau of Licensure and Certification
Health Division – Health Facilities Licensure
1550 East College Parkway, Suite 158
Carson City, NV 89706
(775) 687-4475
(775) 687-6588 (FAX)

d. Division of Mental Health and Developmental Services
505 East King Street
Kinkead Building, Room 602
Carson City, NV 89701-3790
(775) 687-5943
(775) 687-4773 (FAX)

e. Medicaid District Offices

1. Carson City
1100 East Williams Street
Carson City, NV 89701
(775) 684-3652

2. Elko (covers Battle Mountain, Ely and Winnemucca)
850 Elm Street
Elko, NV 89801

3. Fallon (covers Hawthorne, Tonopah and Yerington)
111 Industrial Way
Fallon, NV 89406
(775) 423-3161

4. Las Vegas (covers Henderson and Pahrump)
700 Belrose Street
Las Vegas, NV 89107
(702) 486-1550